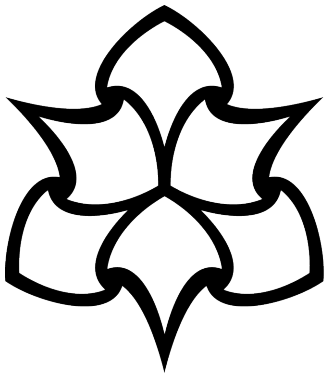

European-wide policymaking at the urban level: A qualitative study

Abstract

Background: Inter-urban area (UA) health inequalities can be as dramatic as those between high and low-income countries. Policies need to focus on the determinants of health specific to UAs to effect change.

Aim: We aimed to determine the degree to which policymakers from different countries could make autonomous health and wellbeing policy decisions for their urban jurisdiction area.

Methods: We conducted a cross-sectional, qualitative interview study with policymakers recruited from 8 European countries (N=37).

Results: The reported autonomy among policymakers varied considerably between countries, from little or no autonomy and strict adherence to national directives (e.g. Slovak Republic) to a high degree of autonomy and ability to interpret national guidelines to local context (e.g. Norway). The main perceived barriers to implementation of local policies were political, and the importance of regular and effective communication with stakeholders, especially politicians, was emphasised. Having qualified health professionals in positions of influence within the UA was cited as a strong driver of the public health agenda at the UA level.

Conclusion: Local-level policy development and implementation depends strongly on the degree of autonomy and independence of policymakers, which in turn depends on the organisation, structure and financial budget allocation of public health services. While high levels of centralisation in small, relatively homogenous countries may enhance efficient use of resources, larger, more diverse countries may benefit from devolution to smaller geographical regions.

Introduction

Globally, around 54% of the world's population now live in cities.[1] Urban populations have become the poorest subset of the global population.[2] Migration into cities is constantly increasing, with the world's urban population rising from 746 million in 1950 to 3.9 billion by 2014.[1]

Urban areas (UAs) can be unhealthy places to live in: high levels of pollution and noise as well as lack of spaces where people can exercise safely can lead to poor health outcomes.[3 4] Healthy, unprocessed foods can be less accessible in cities[5] and deprived areas may also feature overcrowded, sub-standard accommodation.[6]

UAs often differ in health outcomes from the national level,[7 8] and inter-UA health inequalities can be as dramatic as those between high and low-income countries.[9]

A key mechanism for bringing about change in health outcomes for UAs is public health policy.[10] This includes laws, regulations, judicial degrees, guidelines and budget priorities,[1011] to target, for examples, tobacco and alcohol control,[12 13] injury prevention,[14] and taxation of unhealthy foods.[15]

Policies need to focus on the determinants of health specific to UAs in order to effect change. For example, spatial analysis techniques have shown that different factors determine childhood obesity depending on the socioeconomic status of the area, which can help to tailor interventions to the specific needs of different neighbourhoods.[16]

Developing and implementing policy at urban level can be challenging due to the diversity and complexity of UAs.[19 20] Zones such as city centres, industrial, commercial and suburban areas, can differ markedly.[8] Various factors interact within urban environments to create complex problems that place high demands on policy initiatives.[19]

Policies are usually developed and implemented at the national level.[21] It is unclear to what extent UA policymakers are able to influence health policy implementation and how

decisions are made at UA level. This is also likely to vary considerably between different countries, as heterogeneity within a country (e.g. in terms of socioeconomic variables, culture, languages and ethnicity) can affect levels of centralisation. [22] Understanding these complex decision-making processes is crucial to the successful development and implementation of health policy; a failure to understand and address them can lead to policies that fail to produce desired health outcomes.[10]

This important question was explored within the European Urban Health Indicator System projects (EURO-URHIS 1 and 2). EURO-URHIS 1 focused on establishing a network of urban areas across Europe and developing an urban health information and knowledge system.[23] Subsequently, EURO-URHIS 2 was dedicated to developing tools to help policymakers assess and improve the health of urban populations. It involved 14 different countries across Europe and Vietnam, and resulted in the largest set of urban health indicators world-wide.

Results from EURO-URHIS 1 suggested that even when sub-national data is available it is often unused for local policymaking, with decisions still being made at national level.[21] This highlights the need to understand how policy at UA level is developed and implemented as well as the political environment and incentives facing policymakers, in order to provide relevant tools for policymakers, and promote sustainable evidence-informed policymaking.[24]

In this study, we aimed to determine the degree to which policymakers could make autonomous health and wellbeing policy decisions at their urban jurisdiction area, across a wide variation of urban contexts in Europe. We were specifically interested in facilitators and barriers towards implementation of local public health policies, initiatives and interventions at the UA and sub-UA level.

Methods

We conducted a cross-sectional, qualitative interview study with policymakers recruited from 8 European countries. A pilot of the interview process for this proposed study was conducted previously, in response to perceived need for further research in this area. The interview schedule used in the present study used the same questions and some that had evolved through open enquiry with participant policymakers.

In the UK, Directors of Public Health were invited to participate. A pragmatic sampling method for recruiting non-UK interviewees was employed: EURO-URHIS 2 partners were contacted and asked to identify and recommend a senior and appropriate policymaker responsible for public health policymaking in their urban area. A researcher then contacted the potential participants directly by email or telephone. They were invited to include colleagues in the interview if they wished. Where English translation was required, participants were offered the assistance of our project partner.

Each semi-structured interview was carried out by the recruiting researcher (LP) as well as one other member of the research team (AV, JH or SS) according to their availability. These researchers were all experienced in qualitative research methods. All interviews were conducted at participants' place of work. The main focus of enquiry was the geographical level at which policymakers could make decisions about public health (PH) within the context of all healthcare provision at the UA level. Interviews were recorded and transcribed verbatim. Thematic analysis[25] was used to analyse the data. Interview transcripts were first read repeatedly to achieve data familiarisation and to generate initial descriptive codes, which were then grouped into more conceptual themes. Two researchers (LP and MJ) independently undertook coding to enhance rigour and reproducibility.[26] Discrepancies were discussed until consensus was reached. Predominant themes and sub-themes were identified and supporting quotes from policymakers are provided.

Results

Twenty-three interviews (12 UK and 11 non-UK UAs) were conducted in 2012 in 8 countries with a total of 37 subjects. The interviews were representative of North/Central/West/South-Eastern regions in Europe. Interviews were typically 1-1½ hours in length. Interviewees mainly elected to be interviewed on their own (in 14 UAs) or with one additional senior colleague (in 5 UAs); in three instances they included several colleagues (PM18 = 6 participants; PM24 =3; PM43 = 4).

We aimed to recruit the most senior public health representation for the UA jurisdictions and this was achieved in all but one instance. This exception was an interview with senior representatives of a regional PH Bureau. However, they were very familiar with their UA equivalent institution and were able to comment on any differences that would apply for the UA in their responses. The lead contact interviewees were, variously, Directors and Deputy Directors of City Council/Municipal/Regional Departments or Institutions with specific responsibility for PH or overarching responsibility in Health and/or Welfare/Social Care. The non-UK participants included 3 Deputy Mayors.

Theme 1: Autonomy - degree of ability to influence PH policymaking at UA level

For all UAs, healthcare was the overall responsibility of national government with responsibility for the delivery of some aspects devolved to local or regional levels. Table 1 gives a synopsis of the reported ability to influence PH policymaking at the UA.

Overall, the greater the influence of a centralised government and/or the lesser the time since devolution to local jurisdiction for PH policymaking, the lesser the reported satisfaction with, and perceived effectiveness of, the response to local public health challenges. All policymakers reported a preference for using their allocated budgets flexibly in response to local needs, but for those with a greater degree of autonomy, dissatisfaction was expressed about hold-ups due to local-level bureaucracy. Overall, policymakers reported inadequacies in funding for PH initiatives, fears that the situation would deteriorate given increasing

restraints, lack of prioritisation of public health and poor economic circumstances at the national level.

Table 1: Autonomy - degree of ability to influence Public Health policymaking at UA level

Policy maker ID num.	Country	European Region	Country population size[1]	Country geographical size (sq. km)[1]	Theme 1 (T1) Autonomy - degree of ability to influence PH policymaking at UA level (sub-themes T1.1-T1.6)
20 & 21	Slovak Republic	Central	5,426,252	29,035	T1.1 No autonomy - adheres strictly to national directives but UA health agenda planned
11	Romania	South-Eastern	19,511,000	238,391	T1.2 Very little autonomy - prohibitive structure for divergence from national directives
4	Lithuania	Northern	2,827,947	65,300	T1.3 Very little autonomy - expressed little need to diverge from national directives
24 & 25	Slovenia	Central	2,065,879	20,273	T1.4 Some autonomy - compliant with all national directives for health but UA driven inter-disciplinary PH
6 & 16	Latvia	Northern	1,953,200	64,589	T1.5 High degree of autonomy - increasingly able to interpret national directives to local context
1 & 3	Nether-lands	Western	17,100,475	41,543	T1.6 Long established high degree of autonomy - able to interpret national guidelines to local context
18	Norway	Western	5,258,317	385,178	
31-35 & 38-44	UK (England)	Western	54,786,300	130,279	

[1] http://www.worldatlas.com

All but two of the UA representatives indicated that they could influence health policymaking at the UA level to some degree. All had to conform to their country's national directives but most could add policies or interpret these directives according to their UA profile.

Theme 1.1: No UA autonomy

Key informants of UAs from one country reported being unable to influence health policymaking at UA level and adhering uncompromisingly to the national directives (quote #1, Table 2). However, at the time of interview, 1 of the 2 UA key informants interviewed for that country was engaged in the early stages of raising the local focus on and impact for health strategies via specific city-led initiatives (quote #2, Table 2).

Theme 1.2: Very little UA autonomy: prohibitive centralisation

Another country's UAs reported little autonomy but had a mechanism whereby approval needed to be sought for some level of adjustment of the national directives at the UA level (quote #3, Table 2). This policymaker found this situation prohibitively laborious. When asked whether more freedom to make decisions about the UA would be desirable they expressed the need for adequate funding and release from over-restrictive, centralised accountability (quote #4, Table 2).

Theme 1.3: Very little UA autonomy but little expressed need

Although one UA had established mechanisms for making independent PH decisions at the UA level that they exercised to some degree, the policymaker described a burdensome two-step process of gaining approval to diverge from national directives and guidelines via local government approval (quote #5, Table 2).

Despite this the policymaker reported little need to diverge from the national guidelines and rarely did so in practice. However, when asked whether they would like to have more freedom to make decisions for their area of jurisdiction they cited a particular problem regarding alcohol harm reduction that they would like to be able to effect at a local level (quote #6, Table 2).

Theme 1.4: Some UA autonomy

Another UA's policymaker expressed their institution's function with regard to healthcare as primarily compliant with national guidelines but indicated a significant degree of autonomy in formulating and implementing interventions specifically for their UA. They went on to describe a considerable range of PH activities specific to their UA through publicly tendered contracts with NGOs. This policymaker's institution had responsibility for both health and social care for their UA and they also indicated strong working relations within other municipal departments with regard to promoting a PH agenda (quote #7, Table 2).

Theme 1.5: High degree of UA autonomy

One UA policymaker explicitly reported experiencing ongoing and increasing transition to greater UA autonomy for both primary and public health care. They cited World Health Organisation and European Commission initiatives that provide funding and credence to their work as being a highly significant driver for positive change. This UA had also been interviewed during a pilot interview study conducted 4 years before (within the EURO-URHIS 1 project) and had, in the interim, moved from a strong centralised control to greater local autonomy. They reported a positive outlook on this but with fears about the lack of in-country funds to support their efforts at the local level (#quote 8, Table 2).

They reported that a few other UAs in their country were also promoting the health agenda for their city via such initiatives as Health in All and their commitment to gaining and maintaining Healthy Cities status.[27 28] We interviewed the nominated policymaker in another UA in PM16's country and, despite their far smaller population size and density (nearly 1/10 population of PM16), they also had a local dedicated health department that indicated a strong PH awareness in its focus.

Theme 1.6: Long established high degree of UA autonomy

Western European policymakers reported a high degree of long-established responsibility for PH at the UA level compared to those from other European regions. They adhered to national health policy but they reported an ability to make local interpretations of directives and guidance to suit the specific demographics and evolving challenges within their UA (quote #9, Table 2).

In England, local authorities (LAs) were experiencing a considerable upheaval during the period of the interviews (2012) as responsibility for public health services transitioned from the National Health Service (NHS) to LAs. UK Policymakers generally expressed an expectation that the flexibility for interpretation of national directives to the specific challenges of the UA would continue to hold sway post transition (quote #1-, Table 2).

UK policymakers expressed concern about cutbacks for both health services and LAs driven by the economic downturn but hoped that transition to LAs would provide 'economies of scale' for PH activities via integrated working with departments connected with the wider determinants of health (quote #11, Table 2).

Table 2. Quotes for Theme 1 Autonomy - degree of ability to influence PH policymaking at UA level

Sub-theme	Quote number	Country	Quote
No UA autonomy	1	Slovak Republic	"So the city absolutely does not have any way of changing the policies of the government. They have to obey perfectly the parliament. They do not have an agenda on health it is [all] at the…state level. The [city level] agenda is social services and social care."
No UA autonomy	2	Slovak Republic	"There is…the city strategy…and for this…there are four pillars and one of [these] is health…We have to establish a department that will monitor the health in the city, of the citizens and the impact of policies...This is…[a] new co-operation between the university and the Faculty of Medicine…They have to put it into… the planning of the city...It starts in 2013. The first thing that they want to do is establish this Department of Health that will have some competencies for [local] policies."
Very little UA autonomy: prohibitive centralisation	3	Romania	"…for all public health…they are directly subordinated to the Minister of Health. They have to implement their public health policy as the Minister of Health asks. At the same time, from an administrative point of view they are…co-ordinated by…local government [but if local government] asks something to be done, to be performed by the Public Health Authority, that demand must be approved by the Ministry of Health."
Very little UA autonomy: prohibitive centralisation	4	Romania	"We would very much like to be decentralised [and] would be extremely pleased [to] establish some priorities in…implementing public health policies without approval every time for

Sub-theme	Quote number	Country	Quote
			everything. [In that case more] …money would be…useful"
Very little UA autonomy but little expressed need	5	Lithuania	"…on national level all the decisions…are mainly made by the Ministry of Health…[regarding] decisions made in the local level under supervision of the municipality…the suggestions might be initiated by different institutions such as the Bureau of Public Health or any other organisation that is performing a provision within the municipality but someone in administration of municipality have to consider them and…Local Government have to approve it …"
Very little UA autonomy but little expressed need	6	Lithuania	"...that example that we have about [the proximity of] schools [to places that have] alcohol licences this is…where we could intervene if we had more freedom…maybe freedom is not the right word. More power [is what we need]."
Some UA autonomy	7	Slovenia	"…a lot of prevention is on the local level and…is carried out in clinics and other health institutions and a part of it is carried out by NGOs which are co-financed by the municipality…there are workshops that deal with prevention in terms of how we eat, how we stay active and to deal with alcoholism, diabetes……there are many NGOs and many of them deal with…individual diseases"
High degree of UA autonomy	8	Latvia	"The municipality is co-financing these parts…especially in public health [and] in primary healthcare it's depending more and more on the municipality level so it's more and more in terms of each municipality what the budget pay"
Long established high degree of UA autonomy	9	Netherlands	"The public health area [is] mostly...organised at the local level by regulations at national level…[our local plan is] based first of all on the plan of the national health level and then we [look at] the situation in [UA] and see what kind of problems we have here adding to the

Sub-theme	Quote number	Country	Quote
			directives already given by the national level...And try to identify risk groups, target groups [etc]...and then we sort of formulate an idea where we want to end up. We have to [also discuss] this with the [head] of the city council...even when it's coming from the national but it's also a problem in [UA]...we fine-tune in the sense that [for example] we give more insight into specific race groups."
Long established high degree of UA autonomy	10	UK	"…even when there's...national drivers, which, if you chose to pick those up and run with them…you could do it. So it felt responsive in that sense, but also that the national policy… you could see that that was reflected in [UA] as well [but] there's so much room for innovation still within that framework and the potential to not do things as well. We can all see the…inconsistencies in the way [different UAs] do tackle their similar health problems so even within the national framework… there's other things which you can choose to give more emphasis to."
Long established high degree of UA autonomy	11	UK	So the biggest issue that we face is depletion of the resource base...the workforce is a big issue...we've lost some of the best in the transition...clearly there is the issue of diminishing resources.

Theme 2: Political perspective acting as a barrier to implementation of local policies

This theme emerged through all of our interviewees' responses evidenced by specific incidences as well as generalised concerns that elected politicians, at both local and national level, were often reluctant to implement evidence-based policy decisions where the consequences might be seen to be unpopular. Commerce and representatives of the media were cited as being in the frontline of politicians' concerns (quote #1, Table 3).

Policymakers' reaction to the media's perspective was reported as being filtered through an understanding of the zeitgeist but also predicated by political awareness of current "hot" topics that had and were therefore likely to have a negative impact via press coverage (quote #2, Table 3).

Theme 3: Importance of regular and effective communication especially with politicians

We asked our participants how best to present data to effect changes at UA level, and, at that stage but also in response to enquiries about how health policy decisions are made, many of them responded with comments about the need for regular and effective communication (quote #3, Table 3).

The strategy of targeting specific groups pro-actively was mentioned by several policymakers (quotes #4, #5, Table 3).

Effective communication with stakeholders, including Local Council representatives, was uniformly emphasised as needing to be presented in accessible language and in as short a format as possible (quote #6, Table 3).

Narratives derived from qualitative studies' data, particularly real-life exemplars of people facing specific public health challenges, were also cited as having currency in effective communication with politicians (quote #7, Table 3).

Theme 4: Qualified & engaged health professionals enhance PH agenda facilitation

Having qualified health professionals in positions of influence within the UA was cited as a strong driver in the ability to promote and/or sustain the PH agenda at the UA level (quote #8, Table 3).

This was also echoed by policymakers from UAs with a long-established tradition of autonomous PH policymaking at UA level and by one policymaker who reported having no ability to influence PH policymaking outside of national directives (quote #9, Table 3).

Table 3. Quotes for Themes 2-4.

Theme	Quote number	Country	Quote
Political perspective acting as a barrier to implementation of local policies	1	Lithuania	"There was a...demand...initiated by...[the] Ministry of Healthcare and municipalities were given the task to decide what is the minimal distance from schools, educational institutions...to open the shops to have licence to sell alcohol and schools suggested that it should be around between 500 metres to 2 kilometres. When politicians, local politicians [discussed] that it was just reduced to 50 metres...This kind of shows where they will prioritise their decisions. Is it health or is it commerce? Business wins."
Political perspective acting as a barrier to implementation of local policies	2	Netherlands	"Sometimes…we have [health issues that come] into the news quite often so then we have to react to that somehow although if you see, in terms of the health impact, it might not be so major issue but then…you have to react on that because the media comes into the…political view."
Importance of regular and effective communication especially with politicians	3	Netherlands	"…for example last year we organised a discussion evening with the [head of the city council] and a number of...experts in the field of public health but also connected to the health policy and health in general to see how politics and science interact together…and to see if they can influence each other as well. And we already had an outline where we thought this plan should be going...so the result of that process was that we gained more insight in the wishes of the [head of the city council] but also for ourselves [so that we can] fill in our own policy based on effective things, evidence."
Importance of regular and effective communication especially with	4	UK	"I think one of the ways with senior people is by having special seminars, et cetera. I remember, many years ago, [a PH specialist] ran a seminar for prison governors…which went down very well."

Theme	Quote number	Country	Quote
politicians			
Importance of regular and effective communication especially with politicians	5	UK	"There is something about also having debate and discussion with the appropriate forums and groups…presentation, dialogue. Discussion [is] important."
Importance of regular and effective communication especially with politicians	6	UK	"Really, the simpler, the better without it being dumbed down…but presentation simplified [highlighting] key messages [and with] strong narrative to accompany the data…and analysis… that makes it accessible."
Importance of regular and effective communication especially with politicians	7	UK	"We are very keen on getting experiential data back which is part of the desire to make health everyone's business…we can actually collect people's experiences. Stats only tell you so much. What we want is people's stories. So this is about creating the narrative for [UA] around the experience of its health and wellbeing. For me the narrative is as important as the statistics…collecting the story…I think if I started talking about DALYs and QALYs to my councillors, I would probably get, 'what the heck?' not because they are not highly intelligent people…but it is about…you have to make it real and I am not sure QALYs and DALYs really make it real."
Qualified & engaged health professionals enhance PH agenda facilitation	8	Latvia	"Our head of department is very energetic. She is a [an academic and vocational] doctor and so…understands the health level and politician level so she is trying to reach the politicians and go on for the [health] targets. So…it's [easier] for us to do it."
Qualified & engaged health professionals enhance PH	9	Slovak Republic	"…the situation in [UA] is one of the best in [the] cities [of the country]… it's really important what kind of people are at the position of city governing so…because the city mayor and the vice-mayor are medical

Theme	Quote number	Country	Quote
agenda facilitation			doctors…they understand that...it's very important to influence the health of the citizens...they know if they invest into city's health it will also have an impact on the future productivity of those people."

Discussion

This study explored the degree to which it was possible for policymakers to make autonomous health and wellbeing policy decisions for their urban jurisdiction area. We identified considerable variations in the autonomy of policymakers at the urban level, with policymakers generally striving for more independence and flexibility. Political perspectives often acted as barriers to implementing evidence-based local policies. Facilitators to policymaking at UA level included regular and effective communication with experts, local politicians and non-medical stakeholders as well as having qualified health professionals in positions of influence within the UA.

Autonomy and public health structures

Most of the interviewed policymakers reported being able to influence the implementation of national policies in their local context to some degree. Levels of autonomy varied from no autonomy and a strict adherence to national directives, to high levels of autonomy, where policymakers had the authority and capacity to interpret and tailor national directives to the local context.

The lowest level of autonomy was reported by policymakers from Slovakia where the public health network is overseen by the Ministry of Health, and is financed solely from state budget.[29] The 36 regional Public Health Institutes act as executive bodies of the Public Health Authority (PHA), which is responsible for initiating public health measures and legislation.[29] This hierarchical structure and centralised budget allocation helps to explain

why policymakers perceived a very low degree of autonomy. Similarly, Romania and Lithuania, where policymakers also reported low levels of autonomy, have centralised structures, with the Ministry of Health assuming responsibility for principal public health service guidelines. These two countries have more regional responsibility than Slovakia. In Romania, District Public Health Authorities are granted responsibility for the provision of public health services locally,[30] and in Lithuania, municipal public health bureaux are responsible for various local functions, such as implementation of local public health programmes, and population health monitoring.[31]

In larger countries, it can be costly (in terms of administrative costs) and difficult (due to a greater diversity of preferences, culture, languages and identity) to centralise decision-making.[22] In small countries with relatively homogenous populations centralisation can be easier to implement and more efficient in terms of resources. Thus, it was unsurprising to find that relatively small countries like Slovakia and Lithuania should have lower levels of autonomy. In Romania, which covers a large geographical area with almost 20 million inhabitants and 21 different minority languages, a strongly centralised structure seems less justified.[32]

Policy-makers from Slovenia and Latvia reported considerable autonomy. In Slovenia, public health was primarily the responsibility of the National Institute of Public Health and nine regional public health institutes, indicating a trend towards a de-centralised structure.[33] Public health initiatives at local level were often funded by alternative sources (public and private),[33] suggesting less financial dependence of central government funds than in Slovakia. This may have contributed to the higher perceived degree of autonomy among Slovenian policymakers. Since the interviews were conducted, public health institutes have been restructured, involving an increase in the number of regional units,[33] indicating a further shift towards more autonomy for municipalities. Latvian municipalities can implement and

finance local initiatives, and practical health promotion work is often commissioned to municipalities.[34]

Policymakers from the Netherlands, Norway and England reported a long established, high degree of autonomy. Given the countries' relatively larger size in terms of population and/or area, low levels of centralisation were expected in these countries.[22] In the Netherlands, public health functions fall under the authority of municipalities. In Norway, the responsibility for public health rests with the Ministry of Public Health and various other central bodies, but public health activities are implemented and executed at municipal level, and municipalities are also expected to collect data regarding their population's health, and use this to inform their public health strategies.[35] In England, the responsibility for public health primarily falls under the Department of Health (DoH), but the public health services are delivered via various departments, bodies, and LAs.[36] There are nine regional public health groups, and 10 strategic health authorities, through which the DoH operates at a regional level.[36]

Public Health in England was undergoing a considerable restructure at the time of the interviews, as responsibility was transitioning from the NHS to LAs,[37] with consequent uncertainty regarding future levels of autonomy in interpreting national directives. This reform was evaluated in a 2015 King's fund review and found to have had "damaging and distracting" effects, due to "top-down reorganisation" with decisions made at a high, centralised level rather than driven by the wishes and needs of health professionals and patients.[38]

Striving for greater autonomy

Policymakers from three countries in our study reported no or very little autonomy in implementing local policies. In the Slovak Republic, the interviewee described efforts to create and promote city-led initiatives, indicating policymakers strove for more area-specific tailoring. In the countries where very little autonomy was reported (Romania and Lithuania), interviewees described laborious and restrictive processes required to change policy

implementation for the local level, suggesting a wish for greater flexibility. While one interviewee reportedly felt little need to adapt national policies, they did identify an area in which greater autonomy would be beneficial.

Greater autonomy is linked to an enhanced ability to effect change when local, specific problems can be targeted: The results of focussed local population surveys have been found to evoke greater interest and commitment among local agencies, which in turn enhances policymakers' ability to bring about tangible changes that address their local communities' specific needs and priorities.[39]

It should be noted, however, that high levels of local autonomy may not always lead to improvements in public health initiatives. For example, a US-based study which examined differences in evidence-based decision-making among local health departments found considerable variations, and this was related to training and expertise within the workforce.[55] Thus high levels of autonomy coupled with limited or no relevant training among the policymaking workforce could potentially lead to implementation of strategies that are not evidence-based. Additionally, in our study those with a greater degree of autonomy expressed dissatisfaction with hold-ups due to local-level bureaucracy.

Barriers and facilitators to policy implementation

Policymakers commented on barriers that prevented them from implementing evidence-based policies in their urban jurisdiction areas. The main barrier was the tendency of politicians to drive forward popular, rather than evidence-based, initiatives. This is well established in the literature.[41 42] Indeed, policymakers themselves can also be ideologically biased.[43] In order to ensure the popular choice is also the health-promoting choice, it is necessary to mobilise the public, e.g. through streamlining of public information and strengthening of media advocacy.[44] Public health approaches need to focus not only on communication between politicians and health professionals, but also include the general public in the discussion, including collaboration between diverse stakeholders from various

sectors.[44] Research also emphasises the role of the media in shaping public opinions about policies[45 46] and suggests that a more independent media that takes a more critical stance towards industry perspectives is required.[47]

How can policy implementation at UA level be improved?

Evidence alone is not sufficient to drive forward effective policies that will protect and promote public health.[20 48] Interviewees in this study made several suggestions for improving policymaking at urban level.

Participants suggested that policymaking at UA level could be improved by regular and effective communication with local politicians and other stakeholders. Participants emphasised that communication of evidence needs to be short and accessible (key points, lay language) in order to facilitate translation into policy.[49] Policymakers also suggested that evidence is more effectively communicated when accompanied by meaningful narratives, particularly real life examples of people facing public health challenges. Research has shown that a combination of statistical and narrative evidence is most likely to lead to attitude change,[50] and that narratives can help to illustrate how evidence is meaningful to individual people.[51] Moreover, research suggests that evidence is most effective when tailored to the specific constituents of respective policymakers, by expressing data in ways that is meaningful to the recipients and highlights how it is relevant at the local (voting district) level.[49] Overall, our findings, combined with insights from previous literature, show that if we want to promote local-level policymaking, we need not only local-level data, but also strategies to present the evidence in a way that highlights the relevance to both local residents and local issues.

Another common theme expressed by policymakers was that qualified health professionals in positions of influence within the UA can lead to improved policymaking. It is well established that integrating policies into routine daily healthcare practice involves major difficulties.[53] Previous research has emphasised that policies are more likely to be

implemented successfully if they take the experience and knowledge of healthcare providers into account, and when they are supported and endorsed by providers.[54]

Strengths and limitations

A key strength of this study relates to the geographic diversity of the interviewed policymakers; we were able to interview policymakers from 8 different European, achieving representation from North/Central/West/South-Eastern regions in Europe and therefore ensuring perspectives from different contexts were incorporated. Importantly, we succeeded in recruiting senior public health representation from each respective UA jurisdiction (excepting one case where a senior representative of a regional PH Bureau was interviewed instead).

A main limitation of the present study is that, due to the qualitative nature of the enquiry, the findings do not provide insight into generalisability to the general population of policymakers, nor do they allow causal inferences or predictions.

Conclusion

Local-level policy development and implementation depends strongly on the degree of autonomy and independence of policymakers, which in turn depends on the organisation, structure and financial budget allocation of public health services. In order to make informed decisions regarding best policies for unique local conditions and circumstances, policymakers need local-level evidence. However, evidence alone is insufficient to ensure successful changes in practice. To overcome barriers such as political perspectives, which often lead to popular rather than evidence-based choices, policymakers need to promote long-term engagement of diverse stakeholders, including members of the public, political leaders, the private sector and the media. Successful engagement of stakeholders, particularly politicians, will require regular and effective communication, which is most effective when it is presented alongside narratives that highlight relevance to local constituents.

Declarations of interest

None.

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